No. 2
1-4-41
-17-39
X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. E. C. Robichaux

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 7 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24867

Registration District No. 198 Primary Registration District No. 3011 Registrar's No. 104

1. PLACE OF DEATH

(a) County Clay

(b) City or town Excelsior Springs (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 55 yr. 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED: 024

(a) State Mo (b) County Clay

(c) City or town Excelsior Springs (If outside city or town limits, write "RURAL")

(d) Street No. 303 East Excelsior Street (If rural, give location)

(e) Citizen of foreign country? X (Yes or No)

If yes, name country X 0

3. (a) PRINT FULL NAME ELIZABETH RODAWAY.

3. (b) If veteran, name war No

3. (c) Social Security No. NO

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Samuel Rodaway

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Feb (Month) 17 (Day) 1859 (Year)

8. AGE: Years	Months	Days	If less than one day
82	5	12	X hr. X min.

9. Birthplace Canton (City, town, or county) Ohio (State or foreign country)

10. Usual occupation at Home

11. Industry or business

FATHER
12. Name Samuel S. Witwer
13. Birthplace (City, town, or county) Penn (State or foreign country)

MOTHER
14. Maiden name Mary Mistyler
15. Birthplace (City, town, or county) Penn (State or foreign country)

16. (a) Informant Mrs L. J. McCaurent

(b) Address 415-E10 Coffeyville Kans

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31-41 (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Herbert Hope

(b) Address Excelsior Springs Mo

19. (a) (Date received local registrar) (b) 180 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1941 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from July 19 19 to July 29 19 41 that I last saw her alive on July 29 19 41 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
General arteriosclerosis	yrs.
Due to	
Due to	
Other conditions Malnutrition. (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. C. Robichaux (M. D. or other) MD.

Address Ex. Spgs Mo Date signed 7/31-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 8-5-41
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. 3597

working under my personal supervision.

Signed Geo Rockensmith

Licensed Embalmer No. 3597

P. O. Address Excelsior Springs, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24867

Registration District No. 198 Primary Registration District No. 3011 Registrar's No. 164

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Spgs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Elizabeth Podawa
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) July 31-1941 (Date received by local registrar) (b) Mrs Rea McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 29 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-24867